

**IN RE: ALLODERM<sup>®</sup> LITIGATION**

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: MIDDLESEX COUNTY

**CIVIL ACTION**

**Case Code: 295**

**FILED**

**OCT 18 2011**

**FACT DISCOVERY ORDER** JUDGE JESSICA R. MAYER

**THIS MATTER** having been opened to the Court jointly by liaison counsel for the plaintiffs and defendant during a case management conference on October 12, 2011; and the parties having consented to the substance of this Order; and for good cause having been shown:

**IT IS** on this 18<sup>th</sup> day of October, 2011,

**ORDERED** as follows:

- I. **Order Governing Fact Discovery.** The purpose of this Fact Discovery Order is to govern discovery in all actions that are filed or transferred to the Superior Court of New Jersey, Law Division, Middlesex County, for consolidated management of *In re AlloDerm<sup>®</sup> Litigation*, Case Code 295.
- II. **Required Disclosures By Plaintiffs.** A plaintiff subject to this order shall serve upon defendant the following:
  - A. A completed "Plaintiff Fact Sheet" attached hereto as Exhibit "A".
  - B. Ten (10) executed and unaddressed authorizations attached hereto as Exhibit "B". As limited by any other order of this court, defendant shall be permitted to issue the executed authorizations to any health care provider or records custodian identified in Plaintiff's Fact Sheet. If plaintiff is making a wage loss claim, defendant shall be permitted to issue the executed authorizations to any employer identified in Plaintiff's Fact Sheet. When defendant intends to request records from any health care provider, employer, or records custodian identified in Plaintiff's Fact Sheet, defendant shall notify plaintiff's counsel and plaintiff's counsel shall have five (5) business days in which to object. In the event that defendant identifies any additional health care provider, employer, or records custodian from whom defendant believes records can be sought, defendant shall notify plaintiff's counsel by e-mail with the name of said healthcare provider,

employer or records custodian and the date(s) of treatment or employment. Plaintiff shall be given five (5) business days in which to object.

- C. Copies of all medical records in plaintiff's or his/her legal counsel's possession, including but not limited to, any pre- or post- operative photographs of plaintiff's surgical site.
- D. Copies of all LifeCell documents, including but not limited to, any marketing materials, pamphlets, brochures, etc., in plaintiff's possession or that plaintiff provided to his/her legal counsel.

**III. Time Of Plaintiffs' Disclosures.**

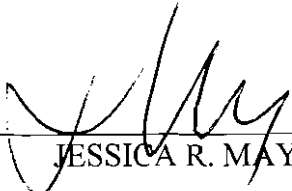
- A. Plaintiffs who filed their cases before the date of this Order shall serve defendant with the information requested in Section I.B.9.A and I.B.9.B of the Plaintiff Fact Sheet no later than sixty (60) days from the date of this Order.
- B. Plaintiffs who filed their cases before the date of this Order shall serve defendant with the documents in Section II.A of this Order no later than ninety (90) days from the date of this Order.
- C. Plaintiffs who filed their cases after the date of this Order shall serve defendant with the documents in Section II.A of this Order no later than ninety (90) days after the filing of their Short Form Complaint.

**IV. Required Disclosures By LifeCell.** For every filed case, LifeCell shall serve upon counsel for plaintiff a completed "Defense Fact Sheet" attached hereto as Exhibit "C" as well as additional requested documents.

**V. Time Of LifeCell's Disclosures.** LifeCell shall serve counsel for plaintiff with the responses and documents in Section II.C of this Order no more than ninety (90) days from the date LifeCell receives the information requested in Section II.B of this Order.

**VI. Preservation Of Records.** To the extent required by the New Jersey Court Rules, documents, including electronic files, in the possession or control of any party, including but not limited to individual plaintiffs, shall be preserved and retained until final resolution of their case or upon further notice of this court.

**VII. Privileged Documents.** Privilege logs shall be created and maintained during the discovery process or pursuant to subsequent agreement of the parties in accordance with the New Jersey Court Rules.

  
JESSICA R. MAYER, J.S.C.

# **EXHIBIT A**

IN RE: ALLODERM® LITIGATION

SUPERIOR COURT OF NEW JERSEY  
LAW DIVISION: MIDDLESEX COUNTY

CASE NO. 295

CIVIL ACTION

PLAINTIFFS,

*Plaintiff,*

v.

LIFECCELL CORPORATION

*Defendant.*

PLAINTIFF'S FACT SHEET

Name of Plaintiff (Print)\_\_\_\_\_ Docket No. \_\_\_\_\_

Name of Person Completing Questionnaire (Print)\_\_\_\_\_

**REMEMBER THAT YOU ARE ANSWERING THIS QUESTIONNAIRE UNDER  
PENALTY OF PERJURY THE SAME AS IF YOU WERE ON THE WITNESS STAND  
AT TRIAL IN A COURTROOM.**

**PART I: CLAIM INFORMATION**

A. Communications regarding your injury:

1. Have you ever communicated with LifeCell Corporation about your injury?

YES\_\_\_\_\_ NO\_\_\_\_\_

If you answered yes, identify for each communication:

1. who you contacted including the name, address, and telephone number of each person contacted:\_\_\_\_\_

\_\_\_\_\_

2. when you made contact:\_\_\_\_\_

3. where you made contact:\_\_\_\_\_

4. how you made contact:\_\_\_\_\_

5. any information you provided:\_\_\_\_\_
6. any information you received as a result of the contact:\_\_\_\_\_
7. how long contact was maintained:\_\_\_\_\_
8. why you made contact:\_\_\_\_\_
9. whether you are aware if anyone else has made contact:\_\_\_\_\_
10. whether you have any documentation of your contact:\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

2. Did you communicate with any local, state or federal governmental official or agency (including the United States Food and Drug Administration (FDA)) about your personal injury?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you answered yes, identify for each communication:

1. who you contacted including the name, address, and telephone number of each person contacted:\_\_\_\_\_
2. when you made contact:\_\_\_\_\_
3. where you made contact:\_\_\_\_\_
4. how you made contact:\_\_\_\_\_
5. any information you provided:\_\_\_\_\_
6. any information you received as a result of the contact:\_\_\_\_\_
7. how long contact was maintained:\_\_\_\_\_
8. why you made contact:\_\_\_\_\_
9. whether you are aware if anyone else made contact:\_\_\_\_\_
10. whether you have any documentation of your contact:\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

3. Did you communicate with any doctor about your personal injury?

YES \_\_\_\_\_ NO \_\_\_\_\_

If you answered yes, identify for each communication:

1. who you contacted including the name, address, and telephone number of each person contacted:\_\_\_\_\_
2. when you made contact:\_\_\_\_\_
3. where you made contact:\_\_\_\_\_

4. how you made contact:\_\_\_\_\_
5. any information you provided:\_\_\_\_\_
6. any information you received as a result of the contact:\_\_\_\_\_
7. how long contact was maintained:\_\_\_\_\_
8. why did you make contact:\_\_\_\_\_
9. whether you are aware if anyone else has made contact:\_\_\_\_\_
10. whether you have any documentation of your contact:\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

**B. Bodily Injury Claim**

1. Identify all of the bodily injuries, surgeries, illnesses, emotional injuries and other medical conditions that you allege were caused by the use of AlloDerm in your medical treatment:\_\_\_\_\_

---

---

---

2. As to each injury, surgery, illness or emotional injury identified in your answer to Question 1, answer the following:

- A. How do you know the injury, surgery, illness or emotional injury was caused by AlloDerm:\_\_\_\_\_

---

---

- C. Who told you that the injury, surgery, illness or emotional injury was caused by AlloDerm, and when did they tell you:\_\_\_\_\_

---

---

- D. How and on what approximate date did you first learn that the injury, surgery, illness or emotional injury may have been caused by AlloDerm: \_\_\_\_\_

---

---

E. Have any doctors confirmed that the injury, surgery, illness or emotional injury was caused by AlloDerm? If so, name the doctor(s) and the date(s) on which you were given such confirmation, and summarize what you were told: \_\_\_\_\_

---

---

---

---

---

---

**(Attach additional sheets, if necessary.)**

F. Was AlloDerm used in your:

First incisional/ventral hernia repair procedure?

YES \_\_\_\_\_ NO \_\_\_\_\_

Second incisional/ventral hernia repair procedure?

YES \_\_\_\_\_ NO \_\_\_\_\_

Third or subsequent incisional/ventral hernia repair procedure?

YES \_\_\_\_\_ NO \_\_\_\_\_

For each "YES" answer given, provide the date of the procedure, the Hospital, and the name of the surgeon who performed the procedure:

---

---

---

---

G. Did you have a synthetic mesh implanted to repair a ventral/incisional hernia before you had an AlloDerm implant?

YES \_\_\_\_\_ NO \_\_\_\_\_

3. Identify all nonprescription drugs used by you to treat injury, surgery, illness or emotional injury you contend was caused by AlloDerm, including:

- A. the brand name of the product: \_\_\_\_\_
- B. the name and address of the pharmacies where you purchased the product: \_\_\_\_\_
- C. the frequency with which you used the product: \_\_\_\_\_
- D. the dosage: \_\_\_\_\_
- E. the prescribing physicians, if any: \_\_\_\_\_
- F. the reasons why prescribed: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

4. Identify all prescription drugs, medical devices and therapies used by you to treat injury, surgery, illness or emotional injury you contend was caused by AlloDerm, including:

- A. the brand name of the product: \_\_\_\_\_
- B. the name and address of the pharmacies where you purchased the product: \_\_\_\_\_
- C. the frequency with which you used the product: \_\_\_\_\_
- D. the dosage: \_\_\_\_\_
- E. the prescribing physicians, if any: \_\_\_\_\_
- F. the reasons why prescribed: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

5. List by date, hospital, physician and type of procedure all surgeries you have had up to the present date, beginning ten years before the first surgery in which AlloDerm was implanted in you. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

6. For each surgery identified in 5 above, identify each surgery in which AlloDerm, another biological implant, or a synthetic mesh was implanted,

and what type or brand of implant was used. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Have you been treated by any doctor specifically because of a health concern related to AlloDerm?

YES \_\_\_\_\_ NO \_\_\_\_\_

8. If you answered yes, identify:

- A. the date of each visit: \_\_\_\_\_
- B. the name and address of the doctor with whom you treated: \_\_\_\_\_  
\_\_\_\_\_
- C. the reason for your visit: \_\_\_\_\_
- D. the doctor's diagnosis: \_\_\_\_\_
- E. what, if anything, you did following the visit as a result of the diagnosis: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

9. With respect to each surgery in which AlloDerm that was implanted into you that you contend caused you personal injury, identify the following:

- A. Names of surgeon: \_\_\_\_\_
- B. Names of hospital or medical care facility: \_\_\_\_\_  
\_\_\_\_\_
- C. Dates of hospitalization: \_\_\_\_\_
- D. Date of first diagnosis of injury for which AlloDerm was used and description of the injury: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- E. Name of physician who made initial diagnosis of that injury: \_\_\_\_\_  
\_\_\_\_\_

F. Name of physician who recommended surgery be performed:

\_\_\_\_\_

G. Alternatives discussed by the physician regarding products, including but not limited to AlloDerm, for surgery: \_\_\_\_\_

\_\_\_\_\_

H. Summarize what you were told by your physician about AlloDerm

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I. Whether you looked at any warnings, labels, package inserts, sales brochures or documents related to AlloDerm before your surgery, and if so, describe all such documents: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

10. Prior to the surgery in which AlloDerm was implanted into you, what information (verbally or in writing) did your physician provide to you regarding each of the following:

A. Potential side effects from using AlloDerm in your surgery: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Possibility of hernia recurrence or future need for further repair:

\_\_\_\_\_

\_\_\_\_\_

C. Possibility of AlloDerm failure: \_\_\_\_\_

\_\_\_\_\_

D. Possibility of bulging or laxity: \_\_\_\_\_

\_\_\_\_\_

E. Possibility of infection from surgery \_\_\_\_\_

- F. Possibility of other complications from surgery: \_\_\_\_\_  
\_\_\_\_\_
- G. Possibility of abdominal wall inflammation: \_\_\_\_\_  
\_\_\_\_\_
- H. Possibility of bowel obstructions: \_\_\_\_\_
- I. Possibility of pain: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

11. Identify the total amount of your bodily injury damage claim: \_\_\_\_\_
12. Have you received any insurance proceeds for your bodily injury damages?

YES \_\_\_\_\_ NO \_\_\_\_\_

13. If you answered yes, identify:

- A. the name of the insurance company: \_\_\_\_\_
- B. the type of insurance policy: \_\_\_\_\_
- C. the amount of insurance proceeds claimed and received: \_\_\_\_\_
- D. the date you first gave notice to the insurer: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

C. Loss of Income Claim

1. Do you claim loss of wages/income loss/business loss that you attribute to the use of AlloDerm in your medical treatment?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. If you answered yes, identify:

- A. the name and address of your employer at that time: \_\_\_\_\_  
\_\_\_\_\_
- B. the title or job classification that you held at that time: \_\_\_\_\_  
\_\_\_\_\_

- C. date first employed or started business: \_\_\_\_\_  
D. dates of absence from work and reason(s) for absence: \_\_\_\_\_  
\_\_\_\_\_

E. rate of pay/income:

\$ \_\_\_\_\_ weekly  
\$ \_\_\_\_\_ bi-weekly  
\$ \_\_\_\_\_ monthly  
\$ \_\_\_\_\_ annually

- F. Total lost wages to date: (compute): \_\_\_\_\_  
G. Itemize any benefit received from state unemployment/disability benefits/private disability/social security disability during dates of absence from work.

\$ \_\_\_\_\_ daily for [       ] days  
\$ \_\_\_\_\_ weekly for [       ] weeks  
\$ \_\_\_\_\_ monthly for [       ] months  
\$ \_\_\_\_\_ Total

3. Did you use sick days, vacation days, personal days, etc. for your lost time at work?

YES \_\_\_\_\_ NO \_\_\_\_\_

4. If you answered yes, identify:

- A. the number of days used: \_\_\_\_\_  
B. the hourly or daily rate used to compute your compensation: \_\_\_\_\_  
\_\_\_\_\_

**(Attach additional sheets, if necessary.)**

## **PART II: PERSONAL INFORMATION**

1. Last Name: \_\_\_\_\_  
First Name: \_\_\_\_\_  
Middle Name or Initial: \_\_\_\_\_
2. Maiden or other names used or by which you have been known and dates of their use: \_\_\_\_\_
3. Social Security Number: \_\_\_\_\_
4. Date of Birth: \_\_\_\_\_
5. Sex: Male ☐ Female ☐
6. Present Street Address: \_\_\_\_\_  
\_\_\_\_\_  
City State Zip Code
7. Who resides with you?  
  
A. Names: \_\_\_\_\_  
B. How long: \_\_\_\_\_
8. How long have you resided at this address? \_\_\_\_\_
9. Identify all addresses at which you have lived during the last 10 years and the years lived at each address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional sheets, if necessary)

## **PART III: EMPLOYMENT AND MILITARY INFORMATION**

**\*\*Complete only if you are making a wage loss claim**

1. Identify your current or last employer: \_\_\_\_\_
2. Employer's Address: \_\_\_\_\_

3. Dates of Employment: \_\_\_\_\_
4. Occupation: \_\_\_\_\_
5. Fill in the table below listing all jobs you have worked for the past ten years including short-term, seasonal, part-time employment, and military service. Begin with your most recent job. (**Attach additional sheets, if necessary.**)

Dates of Employment	Job Title and Description of Work

6. Occupational Personal injury Sources

- A. Have you ever been off work for more than one day because of an illness related to work?

YES \_\_\_\_\_ NO \_\_\_\_\_

- B. Have you ever been advised to change jobs or work assignments because of any health problems or injuries?

YES \_\_\_\_\_ NO \_\_\_\_\_

- C. Has your work routine changed within the 5 years?

YES \_\_\_\_\_ NO \_\_\_\_\_

- D. If you have answered yes to any of the questions above, provide a brief narrative of the particular situation. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

7. Have you ever served in any branch of the U.S. Military?

YES \_\_\_\_\_ NO \_\_\_\_\_

8. If you answered yes, identify:

- A. the branch and dates of service: \_\_\_\_\_
- B. whether you were discharged for any reason relating to your health or physical condition, and if so identify the condition: \_\_\_\_\_  
\_\_\_\_\_

9. Have you ever been rejected from military service for any reason relating to your health or physical condition?

YES \_\_\_\_\_ NO \_\_\_\_\_

10. If you answered yes, identify what that condition was: \_\_\_\_\_

11. Have you ever filed a worker's compensation claim?

YES \_\_\_\_\_ NO \_\_\_\_\_

12. If you answered yes, identify:

- A. the date the claim was filed: \_\_\_\_\_
- B. where the claim was filed: \_\_\_\_\_
- C. claim/docket number, if applicable: \_\_\_\_\_
- D. the nature of disability: \_\_\_\_\_
- E. the period of disability: \_\_\_\_\_
- F. how disability occurred: \_\_\_\_\_
- G. the name of your attorney, if applicable: \_\_\_\_\_
- H. the date and nature of each treatment you had (including identification of all tests and x-rays taken): \_\_\_\_\_
- I. the total amount of money you recovered on the claim: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

13. Have you ever filed a social security disability claim?

YES \_\_\_\_\_ NO \_\_\_\_\_

14. If you answered yes, identify:

- A. the year the claim was filed: \_\_\_\_\_

- B. where the claim was filed: \_\_\_\_\_
- C. the nature of disability: \_\_\_\_\_
- D. the period of disability: \_\_\_\_\_
- E. how disability occurred: \_\_\_\_\_
- F. the name of your attorney, if applicable: \_\_\_\_\_
- G. the date and nature of each treatment you had (including identification of all tests and x-rays taken): \_\_\_\_\_
- H. the total amount of money you recovered on the claim: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

#### **PART IV: PRIOR LITIGATION**

1. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. If you answered yes to IV.1., identify:

- A. the date each lawsuit was filed: \_\_\_\_\_
- B. the type of action: \_\_\_\_\_
- C. your role in the case: \_\_\_\_\_
- D. the attorneys who represented you: \_\_\_\_\_
- E. the court or county where the lawsuit was filed: \_\_\_\_\_
- F. the docket number of each lawsuit: \_\_\_\_\_
- G. the result of the suit: \_\_\_\_\_

3. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to injuries sustained from a hernia mesh or repair product?

4. If you answered to yes to IV.3, identify whether the lawsuit involved a hernia

- A. the date each lawsuit was filed: \_\_\_\_\_
- B. the type of action: \_\_\_\_\_
- C. your role in the case: \_\_\_\_\_
- D. the attorneys who represented you: \_\_\_\_\_
- E. the court or county where the lawsuit was filed: \_\_\_\_\_
- F. the docket number of the lawsuit: \_\_\_\_\_
- G. the result of the suit: \_\_\_\_\_

5. Have you ever given deposition testimony, trial testimony, or any other type of sworn statement (such as an affidavit) in a lawsuit or hearing related to any personal injury that you sustained?

YES \_\_\_\_\_ NO \_\_\_\_\_

6. If you answered yes, identify:

- A. the date each lawsuit was filed: \_\_\_\_\_
- B. the type of action: \_\_\_\_\_
- C. your role in the case: \_\_\_\_\_
- D. the attorneys who represented you: \_\_\_\_\_
- E. the court or county where the lawsuit was filed: \_\_\_\_\_
- F. the docket number of each lawsuit: \_\_\_\_\_
- G. the result of the suit: \_\_\_\_\_

#### **PART V: FAMILY INFORMATION**

1. Are you currently married? YES \_\_\_\_\_ NO \_\_\_\_\_

2. Spouse's name: \_\_\_\_\_

3. Spouse's date of birth: \_\_\_\_\_

4. Spouse's occupation: \_\_\_\_\_

5. Have you ever been separated or divorced? YES \_\_\_\_\_ NO \_\_\_\_\_

6. If you answered divorced, identify:

- A. the name of your former spouse: \_\_\_\_\_
- B. the date of marriage: \_\_\_\_\_
- C. the date of divorce: \_\_\_\_\_

**PART VI: CURRENT MEDICAL CONDITION**

1. Identify your current healthcare insurance providers and provide the following information:
  - A. the address of your current healthcare provider: \_\_\_\_\_
  - B. the dates of coverage (i.e., policy period): \_\_\_\_\_
  - C. the nature of any and all claims made under the policy, including the name of the claimant and description of the injury suffered: \_\_\_\_\_
  - D. the named insured on the policy: \_\_\_\_\_
  - E. whether your policy contains a co-pay or premium method of payment: \_\_\_\_\_
  - F. whether any attorneys are paying or subsidizing your medical bills: \_\_\_\_\_
2. Have you had any surgeries other than those you identified above (relating to the injuries you relate to Alloderm)?  
  
YES \_\_\_\_\_ NO \_\_\_\_\_
3. If you answered yes, for each surgery, identify:
  - A. the nature and extent of the surgery: \_\_\_\_\_
  - B. the date and place of the surgery: \_\_\_\_\_
  - C. the reason for the surgery: \_\_\_\_\_
  - D. the doctor or other medical professionals involved in performing the surgery: \_\_\_\_\_
  - E. any and all tests conducted before the surgery was performed: \_\_\_\_\_
  - F. any and all tests conducted after the surgery was performed: \_\_\_\_\_
  - G. whether you suffered any temporary or permanent effects of the surgery: \_\_\_\_\_
  - H. whether your lifestyle had to be changed as a result of the surgery: \_\_\_\_\_
  - I. whether you filed a lawsuit as a result of the surgery, including the date, docket number, names of parties, and court where the suit was filed: \_\_\_\_\_
4. Have you ever been required to undergo a physical examination by:  
☐ Your Insurance Company  
☐ Your Employer

- ☐ Your Attorney for litigation purposes
- ☐ Your Union

5. If you checked any box, for each physical identify:

- A. the date of the physical: \_\_\_\_\_
- B. the name and address of the doctor conducting the physical: \_\_\_\_\_  
\_\_\_\_\_
- C. whether you provided a medical history in either oral or written form: \_\_\_\_\_
- D. whether you were diagnosed with any ailments or conditions: \_\_\_\_\_  
\_\_\_\_\_
- E. the reason for the physical: \_\_\_\_\_

6. Have you ever voluntarily submitted to a physical examination?

YES \_\_\_\_\_ NO \_\_\_\_\_

7. If you answered yes, identify:

- A. the date of the physical: \_\_\_\_\_
- B. the name and address of the doctor conducting the physical: \_\_\_\_\_  
\_\_\_\_\_
- C. whether you provided a medical history in either oral or written form: \_\_\_\_\_
- D. whether you were diagnosed with any ailments or conditions: \_\_\_\_\_  
\_\_\_\_\_
- E. the reason for the physical: \_\_\_\_\_

8. State your current height, weight, waist size (circumference): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. State your weight and waist size at or about the date of the first surgery in which you were treated for a hernia and state that date: \_\_\_\_\_  
\_\_\_\_\_

10. Do you currently suffer from any physical injury, illness or disability (other than those you claim are caused by personal injuries previously listed by you)?

YES \_\_\_\_\_ NO \_\_\_\_\_

11. If you answered yes, for each injury, illness, or disability, identify:
- A. the nature of the injury, illness, or disability: \_\_\_\_\_
  - B. the date of onset of the injury, illness or disability: \_\_\_\_\_
  - C. the date you received a medical diagnosis of the injury, illness or disability: \_\_\_\_\_
  - D. the name of the doctor making the diagnosis: \_\_\_\_\_
  - E. the names of any doctor treating the injury, illness or disability: \_\_\_\_\_

**PART VII: MEDICAL BACKGROUND**

1. Check the following box that accurately describes your smoking history:
- never smoked cigarettes ☐  
past smoker of cigarettes ☐  
current smoker of cigarettes ☐
2. If you answered past or current smoker, identify:
- A. for past smoker, identify date on which smoking ceased: \_\_\_\_\_  
amount smoked: \_\_\_\_\_ packs per day for: \_\_\_\_\_ years
  - B. for current smoker, identify:  
amount smoked: \_\_\_\_\_ packs per day for: \_\_\_\_\_ years
3. Do you now or have you in the past consumed alcoholic beverages?
- YES \_\_\_\_\_ NO \_\_\_\_\_
4. If you answered yes, check the following box which represents your normal weekly consumption
- 1-5 drinks per week ☐  
6-10 drinks per week ☐  
15 or more drinks per week ☐
5. Have you ever been treated with or otherwise used cortico-steroids, either as a medical therapy or otherwise?
- YES \_\_\_\_\_ NO \_\_\_\_\_

6. If you answered yes, please describe your use in terms of frequency, amount, length of use and time period in which steroids were used by you: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

7. If you have a claim for mental or emotional injury over and above that usually associated with the physical injuries claimed as a result of AlloDerm, state whether you have experienced or been treated for any psychological, psychiatric or emotional problem at any time since your 18<sup>th</sup> birthday.

YES \_\_\_\_\_ NO \_\_\_\_\_

8. If you answered yes, for each condition identify:

- A. name and address of each person who treated you: \_\_\_\_\_  
B. the condition for which you were treated: \_\_\_\_\_  
C. the dates you were treated: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

9. Have you ever been told by a doctor or any other health care provider, that you have, may have or had any of the following:

- |    |  |     |       |    |       |
|----|--|-----|-------|----|-------|
| A. | Hypertension or high blood pressure  | Yes | _____ | No | _____ |
| B. | Heart attack   | Yes | _____ | No | _____ |
| C. | Stroke   | Yes | _____ | No | _____ |
| D. | Chronic lung disease   | Yes | _____ | No | _____ |
| E. | Interstitial lung disease  | Yes | _____ | No | _____ |
| F. | Congenital abnormality of heart  | Yes | _____ | No | _____ |
| G. | Congenital abnormality of lungs; thorax or diaphragm   | Yes | _____ | No | _____ |
| H. | Hypoxia  | Yes | _____ | No | _____ |
| I. | Hypertension   | Yes | _____ | No | _____ |
| J. | Pulmonary vasculitis or other vascular disease   | Yes | _____ | No | _____ |
| K. | Immune system disease, dysfunction (including Aids or HIV), or other disorder involving a suppressed immune system | Yes | _____ | No | _____ |
| L. | Rheumatic fever  | Yes | _____ | No | _____ |
| M. | Cirrhosis, hepatitis or other liver disease  | Yes | _____ | No | _____ |

N.	Alcoholism	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
O.	Cancer				
	If yes, specify : <input type="text"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	<hr/>				
	If yes, did you receive radiation treatment?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
P.	Neurological problem				
	If yes, specify: <input type="text"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	<hr/>				
Q.	Ankylosing spondylitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
R.	Endocarditis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
S.	High cholesterol	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
T.	Marfan's Syndrome	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
U.	Anorexia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
V.	Bulimia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
W.	Diabetes mellitus or other form of diabetes				
	If yes, specify the type: <input type="text"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	<hr/>				
X.	Hypoglycemia (low blood sugar)	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Y.	Kidney disease/renal insufficiency	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Z.	Dermatomyositis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
AA.	Lupus	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
BB.	Rheumatoid Arthritis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
CC.	Connective Tissue Disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
DD.	Scleroderma	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
EE.	Other autoimmune disease				
	If Yes, specify: <input type="text"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
	<hr/>				
FF.	Scarlet fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
GG.	Anemia	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
HH.	Thyroid disorder	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
II.	Non Malignant Tumors	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
JJ.	Asthma or emphysema	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
KK.	Coronary artery disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
LL.	Other heart or lung disease	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
MM.	History of infections	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
NN.	Metabolic syndrome	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
OO.	COPD	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
PP.	Appendicitis	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

QQ.	Surgery for intestinal disorder	Yes	_____	No	_____
RR.	History of significant wound infection	Yes	_____	No	_____
SS.	Malnutrition	Yes	_____	No	_____

10. If you answered yes to any of the above, for each condition identify:

- A. the nature and extent of the condition: \_\_\_\_\_
- B. the date of onset of the condition: \_\_\_\_\_
- C. the name and address of any treating physician: \_\_\_\_\_

### **PART VIII: CAUSATION**

1. Have you had discussions with any doctor about whether any of the injuries for which you are seeking compensation were related to the use of AlloDerm in your medical treatment?

YES \_\_\_\_\_ NO \_\_\_\_\_

2. If you answered yes, check the following that apply:

- A. I was told my condition is related to AlloDerm. \_\_\_\_\_
- B. I was told my condition is not related to AlloDerm. \_\_\_\_\_
- C. I was told my condition may be related to the use of: \_\_\_\_\_
- D. I was told by the doctor that the doctor does not know whether my condition is related to the use of AlloDerm. \_\_\_\_\_
- E. I don't recall what I was told. \_\_\_\_\_

3. Identify the name and address of each doctor with whom you have consulted: \_\_\_\_\_

**(Attach additional sheets, if necessary.)**

### **DECLARATION**

I declare under penalty of perjury under the laws of the State of New Jersey that all of the information provided in this Questionnaire is true and correct to the best of my knowledge, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, and that I have supplied the authorizations attached to this declaration.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**LIST OF MEDICAL PROVIDERS  
AND OTHER SOURCES OF INFORMATION**

EACH PLAINTIFF WHO IS REQUIRED TO COMPLETE A QUESTIONNAIRE MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

List the name and address of each of the following:

- A. Your current family physician:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

- B. To the best of your ability, identify each of your primary care physicians for the past twenty (20) years.

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Approximate  
Date

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

2.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Approximate  
Date

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

3.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Approximate Date

\_\_\_\_\_

Last known address

\_\_\_\_\_  
City, State, Zip Code

4.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Approximate Date

\_\_\_\_\_  
Last known address

\_\_\_\_\_  
City, State, Zip Code

- C. List the name and address of each insurance company or HMO that has provided insurance coverage for the medical bills that you claim have been incurred as a result of your alleged injuries and/or conditions:

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Policyholder's Name

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Amount Claimed/Paid

2.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Policyholder's Name

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Amount Claimed/Paid

3.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Policyholder's Name

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Amount Claimed/Paid

4.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
Policyholder's Name

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Amount Claimed/Paid

- D. Each oncologist, immunologist, hematologist, cardiologist, pulmonary physician and/or heart, lung or chest surgeons who has ever seen or treated you.

1.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

2.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

3.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

4.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

---

Street Address

---

City, State, Zip Code

- E. Each hospital where you have ever received in-patient treatment in the past twenty (20) years.

1.

---

Name

---

Specialty

---

Street Address

---

City, State, Zip Code

2.

---

Name

---

Specialty

---

Street Address

---

City, State, Zip Code

3.

---

Name

---

Specialty

---

Street Address

---

City, State, Zip Code

- F. Each hospital or healthcare facility where you ever received out-patient treatment (including treatment in an emergency room, or drug/alcohol rehabilitation program) in the past twenty (20) years.

1.

Name

Specialty

Street Address

City, State, Zip Code

2.

Name

Specialty

Street Address

City, State, Zip Code

3.

Name

Specialty

Street Address

City, State, Zip Code

4.

Name

Specialty

Street Address

City, State, Zip Code

G. Each other physician or healthcare provider from whom you ever received treatment with the exception of psychiatrists or psychologists in the past twenty (20) years.

1. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

2. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

3. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

4. \_\_\_\_\_  
Name

\_\_\_\_\_  
Specialty

\_\_\_\_\_  
Street Address

	City, State, Zip Code
5.	Name
	Specialty
	Street Address
	City, State, Zip Code
6.	Name
	Specialty
	Street Address
	City, State, Zip Code
7.	Name
	Specialty
	Street Address
	City, State, Zip Code
8.	Name
	Specialty
	Street Address
	City, State, Zip Code

9.

Name

Specialty

Street Address

City, State, Zip Code

10.

Name

Specialty

Street Address

City, State, Zip Code

- H. **If, but only if,** you claim that you suffered mental or emotional injury over and above that usually associated with the physical injuries claimed as a result of AlloDerm, list each **psychiatrist, psychologist and/or social worker from** whom you ever received treatment in the past twenty (20) years.

1.

Name

Street Address

City, State, Zip Code

2.

Name

Street Address

City, State, Zip Code

3.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

- I. If you ever submitted a claim **for social security disability benefits**, state the name and address of the office which is most likely to have records concerning your claim.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

- J. If you ever submitted a claim for **worker's compensation**, state the name and address of the office which is most likely to have records concerning your claim,

\_\_\_\_\_  
Name

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**[ATTACH ADDITIONAL SHEETS, IF  
NECESSARY, TO COMPLETE EACH SUBSECTION]**

# **EXHIBIT B**

**AUTHORIZATION AND RELEASE  
FOR MEDICAL RECORDS**

To: \_\_\_\_\_ [MEDICAL PROVIDER] \_\_\_\_\_

I hereby authorize the holder of information reliant to the medical diagnosis and treatment of \_\_\_\_\_ [PLAINTIFF] \_\_\_\_\_ (the "Medical Information") to disclose the Medical Information, upon presentation of the Authorization, to and for use by \_\_\_\_\_ [PLAINTIFFS' AND DEFENSE COUNSEL] \_\_\_\_\_ and any of their agents or designees ("the Recipients"). By way of example the Medical Information includes, but is not limited to, the following:

All medical records, physicians' records, surgeons' records, x-rays, CAT scans, MRI films, photographs, and any other radiological, nuclear medicine, or radiation therapy films, pathology materials, slides, tissues, laboratory reports, discharge summaries, progress notes, consultations, prescriptions, physicals and histories, discharge summaries, laboratory reports, medication records, nurses' notes, patient intake forms, correspondence, insurance records, consents for treatments, statements of account, bills, invoices, or any other papers concerning any treatment, examination, periods or stays of hospitalization, confinement, diagnosis or other information pertaining to and concerning the physical condition of \_\_\_\_\_ [PLAINTIFF] \_\_\_\_\_ between \_\_\_\_\_ [DATE] \_\_\_\_\_ and \_\_\_\_\_ [DATE] \_\_\_\_\_.

The Medical Information may be disclosed to and used by the Recipients in connection with a claim brought by myself, my relatives or my heirs. . By signing this authorization, I consent to the disclosure to and use by the Recipients of all Medical Information. You are hereby released from any and all liability in connection with your disclosure of Medical Information to Recipients. I understand that, except as otherwise stated in this authorization, information disclosed pursuant to this authorization may be subject to redisclosure by Recipients and may no longer be protected by privacy laws and regulations.

I understand that drug and alcohol abuse treatment records, psychiatric records, and HIV/AIDS information are accorded specific protection by federal and/or state laws and regulations. I do not consent to the release of these records. I do not consent to the release of these records in signing this authorization.

This Authorization is continuing in nature and is to be given full force and until this authorization expires two (2) years after it is signed. Notwithstanding the immediately preceding sentence, I understand that I may revoke this Authorization at any time prior to its expiration by sending written notice of revocation to \_\_\_\_\_ PLAINTIFFS' AND/OR DEFENSE COUNSEL] \_\_\_\_\_, except to the extent that action already has been taken in reliance on this Authorization. A photocopy of this Authorization shall have the same force and effect as the original.

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Name of Patient Representative (if applicable)

\_\_\_\_\_  
Former/Alias/Maiden Name of Patient

\_\_\_\_\_  
Signature of Parent OR Representative

\_\_\_\_\_  
Patient's Date of Birth

\_\_\_\_\_  
Description of Authority to Act for Patient

\_\_\_\_\_  
Patient's Social Security Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Address

# **EXHIBIT C**

<b>IN RE: ALLODERM® LITIGATION</b>	<b>SUPERIOR COURT OF NEW JERSEY LAW DIVISION: MIDDLESEX COUNTY</b>  <b>CASE NO. 295</b>  <b>CIVIL ACTION</b>
<b>PLAINTIFFS,</b>  <div style="text-align: center;"><i>Plaintiff,</i></div> <b>v.</b>  <b>LIFECELL CORPORATION</b>  <div style="text-align: center;"><i>Defendant.</i></div>	<b>DEFENDANT LIFECELL FACT SHEET</b>

**I. Case Information**

This DFS pertains to the following case:

Case Caption:

Civil Action No:

Date DFS completed:

**II. Implanting Surgeons and/or Healthcare Providers**

For each surgeon and/or healthcare provider identified in Plaintiff's Fact Sheet who inserted AlloDerm in the plaintiff identified above ("Plaintiff"), provide the following documents, if any exist, in the possession of LifeCell:

**A. Communications.**

1. All documents, including letters, emails, or other correspondence, sent by or received by LifeCell from any of Plaintiff's implanting surgeon(s) and/or healthcare provider(s) concerning the use of AlloDerm in Plaintiff's hernia repair surgery or abdominal reconstructive surgery.
2. All documents reflecting a communication between LifeCell and Plaintiff's implanting surgeon(s) and/or healthcare provider(s) concerning the use of AlloDerm in Plaintiff's hernia repair surgery or abdominal reconstructive surgery.

3. All Adverse Event Reports, Complaint Investigation Reports, Complaint Reports, and/or other complaint forms related to the use of AlloDerm in Plaintiff's hernia repair surgery or abdominal reconstructive surgery, received by LifeCell from Plaintiff's implanting surgeon(s) and/or healthcare provider(s), and all follow-up correspondence concerning the complaint.

**B. Sales Calls Information.** For the sales representative(s) who was responsible for the territory covering the Plaintiff's implanting surgeon(s) and/or healthcare provider(s) during the time period identified in Plaintiff's Fact Sheet in which AlloDerm was used in Plaintiff's hernia repair surgery or abdominal reconstructive surgery:

1. The name of the sales representative(s) whose territory included Plaintiff's implanting surgeon(s) and/or healthcare provider(s) for AlloDerm.
2. Call notes or other notes, if any exist, tracking visits by LifeCell representatives for AlloDerm to Plaintiff's implanting surgeon(s) and/or healthcare provider(s) related to the use of AlloDerm in Plaintiff's hernia repair surgery or abdominal reconstructive surgery.
3. All documents, if any exist, related to Plaintiff's implanting surgeon(s) and/or healthcare provider(s) use of AlloDerm in Plaintiff's hernia repair surgery or abdominal reconstructive surgery, or any documents which purport to track Plaintiff's implanting surgeon(s) and/or healthcare provider's practices with respect to the use of AlloDerm in hernia repair surgeries and/or abdominal reconstructive surgeries.

**C. Events**

1. Identify all promotional and/or educational events related to the use of AlloDerm in hernia repair surgeries and/or abdominal reconstructive surgeries, including, but not limited to, lunches, dinner meetings, grand rounds, and CMEs which LifeCell sponsored, promoted, or contributed to the sponsorship or promotion of, to the extent such records reflect that such events were attended by Plaintiff's implanting surgeon(s) and/or healthcare provider(s) who implanted AlloDerm in Plaintiff.
2. Attach all promotional or educational materials which reflect that they were presented or used at an event to the extent LifeCell's records reflect that such event was attended by Plaintiff's implanting surgeon(s) and/or

healthcare provider(s), and such event related to the use of AlloDerm in hernia repair surgeries and/or abdominal reconstructive surgeries.

**D. Employment by LifeCell.**

1. Identify whether Plaintiff's implanting surgeon(s) and/or healthcare provider(s) is/are a member of LifeCell's speaker bureau.
2. Identify whether Plaintiff's implanting surgeon(s) and/or healthcare provider(s) have been/is employed or retained by LifeCell for speaking and/or sales engagements and/or research relating to AlloDerm.
3. Any documents reflecting any contracts and/or payments between LifeCell and Plaintiff's implanting surgeon(s) and/or healthcare provider(s) regarding AlloDerm.